1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 14439 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14406

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Somerset — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 14 Potomac St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 39 Crisfield
d. STREET ADDRESS: 14 Potomac St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN Middle BURKE Last BETTS
4. DATE OF DEATH: Month December Day 23 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 24, 1890
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Crisfield, Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William A. Burke
14. MOTHER'S MAIDEN NAME: Annie Somers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: A. Reese Betts, 14 Potomac St., Crisfield, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Heart attack due to fall. — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO (b): Expired moments after fall down steps.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20d. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fall on icy steps.
20c. TIME OF INJURY Hour a.m. 8:45 XX Month, Day, Year Dec. 23 61
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Residence
20f. (City or town) Crisfield (County) Somerset (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: C G Rawley M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12/26/61
EXAMINER'S NAME (Type): C. G. Rawley, M. D.
Address (Street, city, town, or county): Somerset County, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/27/61
22c. NAME OF CEMETERY OR CREMATORY: Sunnyridge Cemetery
22d. LOCATION (City, town, or country) (State): Crisfield, Maryland

23. FUNERAL DIRECTOR ADDRESS: Bradshaw & Sons, Crisfield, Maryland
24a. REC'D BY REGISTRAR DATE: JAN 2 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kimes

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14440

## CERTIFICATE OF DEATH

Reg. Dist. No. 1407

1. PLACE OF DEATH
a. COUNTY Somerset — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD
c. LENGTH OF STAY IN 1b: 1 HOUR
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Mccready

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: M.D.
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MARION
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LORRIE Middle ANN Last Bishop

4. DATE OF DEATH: Month Dec. Day 11 Year 1961

5. SEX: FEMAL
6. COLOR OR RACE: COL
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 8-1961
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months 7 Days 2
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): /
10b. KIND OF BUSINESS OR INDUSTRY: /
11. BIRTHPLACE (State or foreign country): MARION, SOMERSET
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: RUSSEL Bishop
14. MOTHER'S MAIDEN NAME: FRANCES Bernice HILL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): /
16. SOCIAL SECURITY NO.: /
INFORMANT Address: FRANCES Bishop MARION MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Dil of Heart - Virus Pneumonia - Cerebral
434.4
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Dec. 10 - Dec. 11 - 2:30 AM.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 10, 1961, to Dec 11-, 1961, that I last saw the deceased alive on Dec. 11th, 1961, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George C. Coulbourn M.D.
ADDRESS (Street, city or town, state): MARION Sta. Md
DATE SIGNED: 12/12/61
PHYSICIAN'S NAME (Type): George C. COULBOURN, M.D. MARION Station, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Dec, 13-61
22c. NAME OF CEMETERY OR CREMATORY: Tinley Chapel
22d. LOCATION (City, town, or county) (State): Pomock Somerset md.

23. FUNERAL DIRECTOR'S SIGNATURE: Chandler H. Ward
ADDRESS: marion md
24a. REC'D BY REGISTRAR DATE: DEC 18 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

20793 17XVT

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14441

Reg. Dist. No. 1408

1. PLACE OF DEATH
a. COUNTY: Somerset — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chance
c. LENGTH OF STAY IN 1b: 6 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): at home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chance
d. STREET ADDRESS: Main Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Odell — Middle: — Last: Brown

4. DATE OF DEATH: Month: Dec. — Day: 2 — Year: 1961

5. SEX: male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 10, 1924

9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman

10b. KIND OF BUSINESS OR INDUSTRY: Seafood

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Otis Brown

14. MOTHER'S MAIDEN NAME: Lillian Drummond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 225-20-4836

17. INFORMANT — Address: Nellie Brown, Chance, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.H. Johnson M.D.

EXAMINER'S NAME (Type): R. H. Johnson

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Dec 4-1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 5, 1961

22c. NAME OF CEMETERY OR ~~CREMATORY~~: St. Charles Meth.

22d. LOCATION (City, town, or county) (State): Chance, Somerset Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Leroy Webster — ADDRESS: Princess Anne, Md.

24a. REC'D BY REGISTRAR — DATE: DEC 5 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14442

## CERTIFICATE OF DEATH

14409

1. **PLACE OF DEATH**
a. COUNTY: Somerset — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shelltown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ---

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Shelltown
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: ELODIE — Middle: E. — Last: CROPPER

4. **DATE OF DEATH**: Month: December — Day: 29 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

8. DATE OF BIRTH: July 27, 1883

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Edgar Davis

14. MOTHER'S MAIDEN NAME: Annie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 218-34-9497

17. **INFORMANT** Address: Miss Leanne V. Cropper, Shelltown, Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): acute dil. of heart - Uremia - — INTERVAL BETWEEN ONSET AND DEATH: 10 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): (years) Bronchiectasis - Urine Infection Pneumonia (about 10 days) —

DUE TO (c): Chronic Myocarditis, Nephritis — years —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 —

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) (County) (State) —

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 15, 1961, to 12/29/1961, that (I) (we) last saw the deceased alive on 12/29/1961, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: George C Coulbourn M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/30/61

22c. PHYSICIAN'S NAME (Type): George C. Coulbourn - M.D.

22d. ADDRESS: Marion Station - Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-31-61

23c. NAME OF CEMETERY OR CREMATORY: Rehobeth Presbyterian

23d. LOCATION (City, town, or county) (State): Rehobeth, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Henry A. Watson

ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR DATE: JAN 2 '62

25b. REGISTRAR'S SIGNATURE: Wilma L. Travis

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM II/58

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FOR STATE HEALTH DEPT.

M

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2

2

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 1443 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14410

1. PLACE OF DEATH
a. COUNTY: Somerset — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Edw. W. McCready Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Accomac
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tangier 83 x 3
d. STREET ADDRESS: - - -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DAISY — Middle: REBECCA — Last: DIZE (Dise)

4. DATE OF DEATH: Month: December — Day: 1 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1935

9. AGE (In years last birthday): 26 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Pulaski, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew Lucado

14. MOTHER'S MAIDEN NAME: Frances Fain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Lewis Dise, Tangier, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Ruptured tubal pregnancy — INTERVAL BETWEEN ONSET AND DEATH: 7½ Hrs.

645.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: C. G. Rawley M.D. M.D.

EXAMINER'S NAME (Type): C. G. Rawley, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Crisfield, Md.

DATE SIGNED: Dec. 2, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 5, 1961

22c. NAME OF CEMETERY OR CREMATORY: Private Family Cemetery

22d. LOCATION (City, town, or country) (State): Pulaski, Giles Co., Virginia

23. FUNERAL DIRECTOR — ADDRESS: Bradshaw & Sons, Crisfield, Maryland

24a. REC'D BY REGISTRAR — DATE: DEC 6 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Howe

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VS-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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**FOR STATE HEALTH DEPT.**

**TO DELAY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## 14444 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11111

**1. PLACE OF DEATH**
a. COUNTY: Somerset — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne - Polks Road
c. LENGTH OF STAY IN 1b: life time
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

**2. USUAL RESIDENCE** (Where deceased lived, If institution residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne - RFD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: John — Middle: W. — Last: Gale

**4. DATE OF DEATH**: Month: December — Day: 9, — Year: 19 61

**5. SEX**: Male

**6. COLOR OR RACE**: Colored

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: May 3, 1874

**9. AGE** (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Farmer

**10b. KIND OF BUSINESS OR INDUSTRY**: Self Employed

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: John W. Gale

**14. MOTHER'S MAIDEN NAME**: Anna Waters

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service): No

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Bertha Lee — Address: Salisbury, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II. of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21.** I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R. H. Johnson

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12/15/61

EXAMINER'S NAME (Type): R. H. Johnson, M.D. — M.D.

Address (Street, city, town, or county): Princess Anne, Maryland

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 12/17/61

**22c. NAME OF CEMETERY OR CREMATORY**: Mt. Zion Cemetery

**22d. LOCATION** (City, town, or country) (State): Polks Rd.-Princess Anne, Maryland

**23. FUNERAL DIRECTOR** — ADDRESS

**24a. REC'D BY REGISTRAR** — DATE: DEC 18 '61

**24b. REGISTRAR'S SIGNATURE**: Chas S. Kraus

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FOR STATE HEALTH DEPT.

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1

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 14445 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14112

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Somerset — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smith Island
   c. LENGTH OF STAY IN 1b: 2 Years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rhodes Point

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Somerset
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smith Island
   d. STREET ADDRESS: Rhodes Point
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HELEN — Middle MARIE — Last HEFFNER

4. DATE OF DEATH: Month December — Day 26 — Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 16, 1919

9. AGE (In years last birthday): 42 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Collinsville, Okla.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Orval E. Sullivan

14. MOTHER'S MAIDEN NAME: Mary Fannie Cates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Willis E. Sullivan-- Address: 3522 E. Cambridge Ave. Scottsdale, Arizona

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Barbituate Poisoning --Self-Administered — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour 3:15 p.m. Month, Day, Year Dec. 26 19 61

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: C. G. Rawley M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Dec. 28, 1961

EXAMINER'S NAME (Type): C. G. Rawley, M.D.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 1, 1962

22c. NAME OF CEMETERY OR CREMATORY: Ridgelawn Cemetery

22d. LOCATION (City, town, or country) (State): Collinsville, Okla.

23. FUNERAL DIRECTOR — ADDRESS: Bradshaw & Sons--Crisfield, Maryland

24a. REC'D BY REG.STRAR DATE: JAN 2 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

14446 — Reg. Dist. No. 1443

1. PLACE OF DEATH
a. COUNTY: Somerset — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Princess Anne

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Princess Anne

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS: 1

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Jilianna — Middle — Last Hupke

4. DATE OF DEATH: Month Dec. — Day 29 — Year 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Oct. 18, 1893

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Bavaria

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Johann Rasp

14. MOTHER'S MAIDEN NAME: Veronica Schaumberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Helen Layfield, Princess Anne

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of colon with metastasis — INTERVAL BETWEEN ONSET AND DEATH: 18months

153.4

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 6, 1961, to Dec 29, 1961, that I last saw the deceased alive on Dec 27, 1961, and that death occurred at 5pm M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Everett Sutter M.D. — ADDRESS (Street, city or town, state): Dames Quarter, Md. — DATE SIGNED: 1-1-62

PHYSICIAN'S NAME (Type): Everett C. SutterMD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 1/2/62 — 22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial — 22d. LOCATION (City, town, or county) (State): Salisbury, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James Duncan — ADDRESS: Princess Anne, Md.

24a. REC'D BY REGISTRAR DATE: JAN 5 '62 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Kirk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

14447 14414

**1. PLACE OF DEATH**
a. COUNTY: SOMERSET — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRISFIELD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): EDW. W. McCREADY MEMO. HOSP.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MARION STATION
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First MABEL Middle Last JOHNSON

**4. DATE OF DEATH**: Month DECEMBER Day 7 Year 1961

5. SEX: FEMALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-20-1900
9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House. Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or Foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH JOHNSON
14. MOTHER'S MAIDEN NAME: LAURA COULBORN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ROBERT JOHNSON, MARION, MARYLAND — Address

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dil of Heart, Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Chronic Hypertension
DUE TO (c) Chronic Nephritis
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a) Senile Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year Dec 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 1, 1961 to 12-7-61, 19 ....., that (I) (we) last saw the deceased alive on 12-7-61 19 ... , and that death occured at 11:15AM, from the causes and on the date stated above.

22a. SIGNATURE: George C. Coulbourn M.D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): GEORGE C. COULBOURN, M.D.
22d. ADDRESS: MARION STATION, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec 10-61
23c. NAME OF CEMETERY OR CREMATORY: Family
23d. LOCATION (City, town or county) (State): MARION, SOM, MD

24. FUNERAL DIRECTOR'S SIGNATURE: Charles Hilliard, Marion sta, Md
ADDRESS:
25a. REC'D BY REGISTRAR DATE: DEC 18 '61
25b. REGISTRAR'S SIGNATURE: Chas. L. Thomas

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14449

## CERTIFICATE OF DEATH

Reg. Dist. No. 1416

1 PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ohio d
c. LENGTH OF STAY IN 1b Life Time
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland
b. COUNTY [illegible]
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield X
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First [illegible] Middle T Last [illegible]
4. DATE OF DEATH Month I2 Day I2 Year 19 6I

5. SEX [illegible]le
6. COLOR OR RACE [illegible]olored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4/6/1870
9 AGE (In years last birthday) 91 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler
10b. KIND OF BUSINESS OR INDUSTRY Private Family
11. BIRTHPLACE (State or foreign country) [illegible]
12 CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME [illegible] Jones
14 MOTHER'S MAIDEN NAME Frances Waters

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Address [illegible]

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 3 years
DUE TO (b)
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 15th 1960, to Dec. 12th 1961, that I last saw the deceased alive on Dec 7th 1961, and that death occurred at 7.07 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Eldon G. Kaufman M.D. ADDRESS (Street, city or town, state) Princess Anne, Md DATE SIGNED 12.15.61

PHYSICIAN'S NAME (Type) [illegible]

22a BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF [illegible]
22c. NAME OF CEMETERY OR CREMATORY [illegible]
22d LOCATION (City town, or county) (State) Cris[illegible]

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William H. James Jr. Princess Anne, Md
24a REC'D BY REGISTRAR DATE DEC 18 '61
24b REGISTRAR'S SIGNATURE [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

14448 — 14115

1 (M) 79 (I)

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 7/61

**1. PLACE OF DEATH**
a. COUNTY: SOMERSET — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CRISFIELD
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): EDW. W. McCREADY MEMO. HOSP.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MARION
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First GARFIELD — Middle — Last JONES

**4. DATE OF DEATH**: Month DECEMBER — Day 14 — Year 19 61

**5. SEX**: MALE

**6. COLOR OR RACE**: NEGRO

**7.** MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

**8. DATE OF BIRTH**: JULY 1, 1882

**9. AGE** (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Seafood worker

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): MARYLAND Somerset Co

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: JAMES JONES

**14. MOTHER'S MAIDEN NAME**: NAN COULBOURN

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: 212-14-7388

**17. INFORMANT**: BERNICE JONES, MARION, MARYLAND
Address

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Dil of Heart - Hypertension
DUE TO (b): Cerebral Hemorrhage -
DUE TO (c): Chronic Myocarditis, & Arteriosclerosis

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 13 days — years —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): General Arteriosclerosis

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐ — Yes -

MEDICAL CERTIFICATION

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

**20c.** TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

**20d.** INJURY OCCURRED While at work ☐ Not While at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Dec 1 — 19 61, to 12-14- ..., 1961, that (I) (we) last saw the deceased alive on 12-14-61 ...19...., and that death occured at 8.15 PM, from the causes and on the date stated above.

**22a.** SIGNATURE: George C Coulbourn M.D.

**22b.** DATE SIGNED

ATTENDING PHYS. X — MED. DIRECTOR ☐ — STAFF PHYS. ☐

**22c.** PHYSICIAN'S NAME (Type): GEORGE C. COULBOURN, M.D.

**22d.** ADDRESS: MARION, MARYLAND

**23a.** BURIAL, CREMATION, REMOVAL (Specify): BURIAL

**23b.** DATE THEREOF: Dec 17-1961

**23c.** NAME OF CEMETERY OR CREMATORY: WARD'S MEMORIAL

**23d.** LOCATION (City, town or county) (State): MARION Som, MD

**24** FUNERAL DIRECTOR'S SIGNATURE: Charles H. Ward — ADDRESS: Marion Sta Md

**25a.** REC'D BY REGISTRAR DATE: DEC 22 '61

**25b.** REGISTRAR'S SIGNATURE: Helen L. Kines

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

14450

## CERTIFICATE OF DEATH

14417

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: SOMERSET — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRISFIELD
   c. LENGTH OF STAY IN this place: 11 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): E.W. McCREADY MEMORIAL HOSP.

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: SOMESET
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRISFIELD
   d. STREET ADDRESS: RT 1 OLD STATE ROAD
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ALICE — Middle A. — Last LANE

4. **DATE OF DEATH**: Month DEC — Day 27 — Year 19 61

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-22-1896

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): CRISFIELD MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES BROWN

14. MOTHER'S MAIDEN NAME: ARINTHA TAWES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: VIRGINIA DIZE — Address: CRISFIELD MD.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC HEART DISEASE
DUE TO (b): 420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1. ARTHROSCLEROSIS 2 DIABETES MELITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from DEC 17, 1961, to DEC 27, 1961, that (I) (we) last saw the deceased alive on DEC 27 1961, and that death occured at 9:50 P.M. from the causes and on the date stated above

22a. SIGNATURE: Chas H Lithgow M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-27-61

22c. PHYSICIAN'S NAME (Type): CHAS H LITHGOW, M.D.

22d. ADDRESS: CARSON BUILDING CRISFIELD MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/30/61

23c. NAME OF CEMETERY OR CREMATORY: Crisfield Cemetery

23d. LOCATION (City, town or county) (State): Crisfield, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Bradshaw & Sons, Crisfield, Maryland

25a. REC'D BY REGISTRAR DATE JAN 2 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kiana

VR A1S (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

14451

1118

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1 PLACE OF DEATH
a. COUNTY: SOMERSET
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRISFIELD
c. LENGTH OF STAY IN 1b: 24 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): E. W. McCREADY MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MARION STATION
d. STREET ADDRESS: 1 RFD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First UPSHUR Middle LONG Last

4. DATE OF DEATH: Month DEC Day 18 Year 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 6-19-1879
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State, or foreign country): MARION STATION MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALEX LONG
14. MOTHER'S MAIDEN NAME: GEORGIANNA PRICE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 216-38-9329
17. INFORMANT: DOROTHY MARSHALL, Address: MARION MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Dil[illegible] Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic Interstitial Chronic Myocarditis — Years
DUE TO (c): General Arterio Sclerosis

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from [illegible], 1961 to DEC. 18, 1961, that (I) (we) last saw the deceased alive on DEC. 18 1961 and that death occured at 1:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: George C. Coulbourn M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 12-18-61
22c. PHYSICIAN'S NAME (Type): GEORGE C. COULBOURN, MD
22d. ADDRESS: MARION STATION MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/20/61
23c. NAME OF CEMETERY OR CREMATORY: Sunnyridge Cemetery
23d. LOCATION (City, town or county) (State): Crisfield, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Bradshaw & Sons, Crisfield, Md.
ADDRESS

25a. REC'D BY REGISTRAR DATE DEC 26 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kirwan

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14452 — 1419

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed with.n 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled ... the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 ... should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH — a. COUNTY: SOMERSET — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRISFIELD
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: E.W.McCREADY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) — a. STATE: MARYLAND — b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X REHOBETH
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First WALTER — Middle K — Last MAHAN

4. DATE OF DEATH: Month DECEMBER — Day 24 — Year 1961

5 SEX: M — 6. COLOR OR RACE: W — 7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 8. DATE OF BIRTH: 6-15-1893 — 9. AGE (In years last birthday): 68 yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PREACHER — 10b KIND OF BUSINESS OR INDUSTRY: --- — 11. BIRTHPLACE (State or foreign country): ILLINOIS — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GRANT MAHAN — 14. MOTHER'S MAIDEN NAME: LILLUS KEPNER ~~LILLIAN KEYSNER~~

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ** — 16. SOCIAL SECURITY NO.: 220-34-9558 — 17. INFORMANT — Address: ANNA MAHAN REHOBETH, MARYLAND

**MEDICAL CERTIFICATION**

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

42011

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetic hepatitis — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19 — 20d. INJURY OCCURRED While at work [ ] Not while at work [ ] — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from [illegible], 19[illegible] to DEC. 24, 19 61 that (I) (we) last saw the deceased alive on DEC. 24 1961, and that death occurred at 9 AM from the causes and on the date stated above

22a SIGNATURE: A N Barr — M.D. — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ] — 22b DATE SIGNED: 12-24-61

22c PHYSICIAN'S NAME (Type): A.N. BARR M.D. — 22d. ADDRESS: CRISFIELD MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b DATE THEREOF: 12-27-61 — 23c NAME OF CEMETERY OR CREMATORY: Rehobeth Methodist — 23d. LOCATION (City, town, or county) (State): Rehobeth, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Henry H Watson — ADDRESS: Pocomoke City, Md. — 25a. REC'D BY REGISTRAR DATE: DEC 29 '61 — 25b REGISTRAR'S SIGNATURE: Clifton S. Travers

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

14453 — 14420

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: SOMERSET — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRISFIELD
   c. LENGTH OF STAY IN 1b: 2 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): E.W. McCREADY MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: SOMERSET
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 39 CRISFIELD
   d. STREET ADDRESS: 1 13 CHESAPEAKE AVE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First PERCY — Middle J — Last MARSHALL

4. **DATE OF DEATH**: Month DECEMBER — Day 21 — Year 1961

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: JAN 7, 1904 — 9. AGE (In years last birthday): 57 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian — 10b. KIND OF BUSINESS OR INDUSTRY: Fire Department — 11. BIRTHPLACE (County & State, or foreign country): CRISFIELD MARYLAND USA — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JAMES EDWARD MARSHALL — 14. MOTHER'S MAIDEN NAME: MARY ESTELLE PARKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None — 16. SOCIAL SECURITY NO.: 216-09-3565 — 17. INFORMANT: BLANCHE MARSHALL — Address: 13 CHESAPEAKE AVE CRIS.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 331X Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hard arterio sclerosis — years
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Had first cerebral episode approx. 14 yrs ago. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County, (State)

21. **I certify** that (I) (this hospital) attended the deceased from ... 19 49 to DEC 21, 1961, that (I) (we) last saw the deceased alive on DEC 21 61, and that death occured at 4:40 A.M. from the causes and on the date stated above.

22a. SIGNATURE: C.G. Rawley M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: DEC 21, 1961

22c. PHYSICIAN'S NAME (Type): C.G. RAWLEY, M.D. — 22d. ADDRESS: CRISFIELD, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 12/23/61 — 23c. NAME OF CEMETERY OR CREMATORY: Sunnyridge Cemetery — 23d. LOCATION (City, town or county) (State): Crisfield, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Bradshaw & Sons, Crisfield, Md. — 25a. REC'D BY REGISTRAR DATE: DEC 27 '61 — 25b. REGISTRAR'S SIGNATURE: Clara S. Kiana

VR AIS (4)
15M 7/61

1

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14454

## CERTIFICATE OF DEATH

Reg. Dist. No. 1121

1 PLACE OF DEATH a. COUNTY: SOMERSET — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DAMES QUARTER
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: At home

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DAMES QUARTER X
d. STREET ADDRESS: Main Road 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First LYDIA — Middle — Last MESSICK
4. DATE OF DEATH: Month Dec — Day 4 — Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 10-1897
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeep
10b. KIND OF BUSINESS OR INDUSTRY: Housekeep
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT MESSICK
14. MOTHER'S MAIDEN NAME: JANE MESSICK

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service: NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MARY BOZMAN — Address: DAMES QUARTER MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
DUE TO (b): Arteriosclerotic heart disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): diabetis mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1958 19____ to 12-4-61 19____ that I last saw the deceased alive on 12-4-61 19____, and that death occurred at 3A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Everett C. Sutter M.D.
ADDRESS (Street, city or town, state): Dames Quarter, Maryland
DATE SIGNED: 12-6-61

PHYSICIAN'S NAME (Type): Everett C. SutterMD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec 6-1961
22c. NAME OF CEMETERY OR CREMATORY: Messick Family Cemetery
22d. LOCATION (City, town, or county) (State): Dames Quarter Md

23. FUNERAL DIRECTOR'S SIGNATURE: L. G. Webster
ADDRESS: Princess Anne Md
24a. REC'D BY REGISTRAR DATE: DEC 8 '61
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

14455 Reg. Dist. No. 11422

1. PLACE OF DEATH
a. COUNTY: Somerset — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Somerset

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Crisfield

c. LENGTH OF STAY IN 1b: life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Crisfield X

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maggie Middle: Virginia Last: Nelson

4. DATE OF DEATH: Month: December Day: 23 Year: 19 61

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec.20,1883

9. AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Robert Sterling

14 MOTHER'S MAIDEN NAME: Annie Mosher

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT Address: Alonzo W. Nelwon, Crisfield, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): TOXIC MYOCARDITIS — INTERVAL BETWEEN ONSET AND DEATH: 12/18/61

DUE TO

4 5 0 9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) GENERALIZED ARTERIOSCLEROSIS — UNKNOWN

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ANEURYSIM OF ABDOMINAL AORTA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/18/61, 19____, to 12/23/61, 19____, that I last saw the deceased alive on 12/23/61, 19____, and that death occurred at 10:55 M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE A. N. Barr M.D.

PHYSICIAN'S NAME (Type) A. N. BARR, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 12/26.61

22c. NAME OF CEMETERY OR CREMATORY: Sunnyridge

22d LOCATION (City, town, or county) (State): Hopewell, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: James Newman

ADDRESS: Crisfield, Md.

24a REC'D BY REGISTRAR DATE: JAN 2 '62

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14456

# CERTIFICATE OF DEATH

Reg. Dist. No. 1123

1. PLACE OF DEATH
a. COUNTY: Somerset — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William — Middle: L. — Last: Pryor

4. DATE OF DEATH: Month: Dec. — Day: 29, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Sept. 26, 1886

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Fruitland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Pryor

14. MOTHER'S MAIDEN NAME: Clara Pusey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. William Pryor, Address: Princess Anne, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized Arteriosclerosis — 5 yrs.

DUE TO (c): Diabetes — 6 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 yrs. 19 59, to Dec 29, 1961, that I last saw the deceased alive on Dec 29, 1961, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B. Frank Giganti M.D. — ADDRESS (Street, city or town, state): 2C Prince William St. Princess Anne Md. — DATE SIGNED: 12/30/61

PHYSICIAN'S NAME (Type): B. FRANK GIGANTI

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 31, 1961

22c. NAME OF CEMETERY OR CREMATORY: Allen Cemetery

22d. LOCATION (City, town, or county) (State): Allen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Leon R. Wilson — ADDRESS: PRINCESS ANNE, MD.

24a. REC'D BY REGISTRAR: JAN 2 '62

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14457

Reg. Dist. No. 4121

1. PLACE OF DEATH
a. COUNTY: SOMERSET — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PRINCESS ANNE
c. LENGTH OF STAY IN 1b: 15 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X PRINCESS ANNE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARVEY — Middle M. — Last RUSSELL

4. DATE OF DEATH: Month DEC. — Day 25, — Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 23, 1906

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK BODY BUILDER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): LEEMONT, VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WARREN RUSSELL

14. MOTHER'S MAIDEN NAME: MARGARET HINMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MRS. HARVEY RUSSELL PRINCESS ANNE, MD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ — Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R H Johnson M D — M.D.

EXAMINER'S NAME (Type): R. H. Johnson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12/26/61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 12-27-61

22c. NAME OF CEMETERY OR CREMATORY: BEECHWOOD MEMORIAL PARK

22d. LOCATION (City, town, or county) (State): PRINCESS ANNE, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Leon R Wilson — ADDRESS: PRINCESS ANNE, MD.

24a. REC'D BY REGISTRAR — DATE: DEC 29 '61

24b. REGISTRAR'S SIGNATURE: Clifton L. Evans

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form HM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14458

# CERTIFICATE OF DEATH

Reg. Dist. No. 14125

1. PLACE OF DEATH
a. COUNTY: Somerset
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Deal Island
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Deal Island
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Susie Middle Lee Last Scott

4. DATE OF DEATH: Month December Day 16, Year 1961

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 6, 1882

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Uriah Owens

14. MOTHER'S MAIDEN NAME: Susan Briddell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. John Webster, Princess Anne, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 years

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertension — 5 years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 30th 1958, to Dec 16, 1961, that I last saw the deceased alive on Dec 11th, 1961, and that death occurred at 10:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Elden G. Marksman M.D. ADDRESS (Street, city or town, state): Princess Anne, Md. DATE SIGNED

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/19/61

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek

22d. LOCATION (City, town, or county) (State): Chance Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James Thurman ADDRESS: Princess Anne, Md.

24a. REC'D BY REGISTRAR DATE: DEC 27 '61

24b. REGISTRAR'S SIGNATURE

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

M

X

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9 60

# MARYLAND STATE DEPARTMENT OF HEALTH

**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## 14459 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14426

1. PLACE OF DEATH
   a. COUNTY: Somerset
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chance
   c. LENGTH OF STAY IN 1b: MARYLAND 15 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Somerset
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chance
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Theodore; Middle: ; Last: Taylor

4. DATE OF DEATH: Month: December; Day: 20; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/11/1916

9. AGE (In years last birthday): 45 yrs
   IF UNDER 1 YEAR: Months: ; Days:
   IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Electrical

11. BIRTHPLACE (State or foreign country): Allen, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fred Taylor

14. MOTHER'S MAIDEN NAME: Elizabeth Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes World War II

16. SOCIAL SECURITY NO.: 212-12-3197

17. INFORMANT Address: Pauline Taylor- Chance, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gun shot wound of head
INTERVAL BETWEEN ONSET AND DEATH: Instant

1176X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Due to 22 rifle bullet
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Rifle bullet in head

20c. TIME OF INJURY: Hour: 3 p m; Month, Day, Year: 12 20, 61

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Lane

20f. (City or town) (County) (State): Chance, Somerset Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. H. Johnson _____ M D

EXAMINER'S NAME (Type): R. H. Johnson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 12-22-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec.23,1961

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Church Cemetery

22d. LOCATION (City, town, or country) (State): Chance, Maryland

23. FUNERAL DIRECTOR: L. B. Webster ADDRESS: Funeral Service

24a. REC'D BY REGISTRAR DATE: DEC 26 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Mann

1

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

14460 — 14427

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

**1. PLACE OF DEATH**
a. COUNTY: SOMERSET — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CRISFIELD
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): E. W. McCREADY MEMORIAL HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 39 CRISFIELD
d. STREET ADDRESS: 1 MARINERS ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First JOSEPHINE — Middle — Last WARD

**4. DATE OF DEATH**: Month DECEMBER — Day 2 — Year 1961

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 4-12-1876

**9. AGE** (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): CRISFIELD MD.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: JAMES SOMERS

**14. MOTHER'S MAIDEN NAME**: PRISCILLA MORGAN

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service): No

**16. SOCIAL SECURITY NO.**: NONE

**17. INFORMANT**: EDNA BYRD - CRISFIELD - MD. — Address MARINER'S ROAD

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, Terminal — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): 493 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from ..... 1951, to 12-2, 1961 that (I) (~~saw~~) last saw the deceased alive on Dec 2 1961, and that death occured 4 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: C. G. Rawley M.D.

**22b. DATE SIGNED**: 12/2/61

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22c. PHYSICIAN'S NAME** (Type): C. G. RAWLEY, M.D.

**22d. ADDRESS**: CRISFIELD, MARYLAND

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL

**23b. DATE THEREOF**: 12-5-61

**23c. NAME OF CEMETERY** ~~OR CREMATORY~~: MARINER'S METHODIST

**23d. LOCATION** (City, town or county) (State): CRISFIELD MD.

**24 FUNERAL DIRECTOR'S SIGNATURE**: L. D. Webster — **ADDRESS**: Crisfield Md.

**25a. REC'D BY REGISTRAR** DATE: DEC 11 '61

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Preble

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

14461

## CERTIFICATE OF DEATH

14428

1. **PLACE OF DEATH**
a. COUNTY: SOMERSET — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CRISFIELD
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): EDW. W. McCREADY MEMORIAL HOSP

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 39 CRISFIELD
d. STREET ADDRESS: 5 CHESAPEAKE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: WILLIAM — Middle: ALLEN — Last: WILSON

4. **DATE OF DEATH**: Month: DECEMBER — Day: 28 — Year: 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-28-61

9. AGE (In years last birthday): 111 yrs. — IF UNDER 1 YEAR: Months: 111 Days: 11 — IF UNDER 24 HRS.: Hours: 7 Min.: 35

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: GEORGE THOMAS WILSON

14. MOTHER'S MAIDEN NAME: PEGGY JANE DIGGS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. **INFORMANT** Address: PEGGY WILSON, CRISFIELD, MARYLAND

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): INANITION — INTERVAL BETWEEN ONSET AND DEATH: 7 HRS. 35 MIN

DUE TO (b): PREMATURITY, SIX MONTHS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PRESENTING PART DESCENDING INTO PELVIS AT 5 MONTHS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-28-61, 19 to 9:10AM 12-28-, 1961 that (I) (we) last saw the deceased alive on 12-28- 1961, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: A. N. Barr, M.D. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/28/61

22c. PHYSICIAN'S NAME (Type): A. N. BARR, M.D.

22d. ADDRESS: CRISFIELD, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/29/61

23c. NAME OF CEMETERY OR CREMATORY: St. Paul's Cemetery

23d. LOCATION (City, town or county) (State): Marion Station, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Bradshaw & Sons, Crisfield, Md.

25a. REC'D BY REGISTRAR DATE: JAN 4 '62

25b. REGISTRAR'S SIGNATURE: Clarence L. Evans

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

207915 IX J1